

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I _____, understand that as part of my health care, East Bay Sports Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communications among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for health care operations such as assessing quality and reviewing the competence of health care professions.
- The right to review the notice prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that East Bay Sports Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should East Bay Sports Medicine change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient's Signature (authorized representative signing for patient)

Date